

10-15-2005

Tobacco Abuse and Disability Benefits: Response to the 2003 Meisburg Analysis

Kathryn A. Kroggel

Follow this and additional works at: <http://digitalcommons.pepperdine.edu/naalj>



Part of the [Administrative Law Commons](#), [Disability Law Commons](#), [Health Law Commons](#), [Medical Jurisprudence Commons](#), and the [Social Welfare Law Commons](#)

Recommended Citation

Kathryn A. Kroggel, *Tobacco Abuse and Disability Benefits: Response to the 2003 Meisburg Analysis*, 25 J. Nat'l Ass'n Admin. L. Judges. (2005)
available at <http://digitalcommons.pepperdine.edu/naalj/vol25/iss2/2>

This Article is brought to you for free and open access by the School of Law at Pepperdine Digital Commons. It has been accepted for inclusion in Journal of the National Association of Administrative Law Judiciary by an authorized administrator of Pepperdine Digital Commons. For more information, please contact Kevin.Miller3@pepperdine.edu.

Tobacco Abuse and Disability Benefits: Response to the 2003 Meisburg Analysis

By Kathryn A. Kroggel *

I. INTRODUCTION

Tobacco abuse is the leading cause of preventable disease and death in the United States, contributing to over 440,000 deaths a year.¹ Studies link tobacco use to over thirty distinct illnesses, as well as to effects on, or damage to, almost every organ in the body and a person's overall general health.² Cigarettes came to the

*Ms. Kroggel is an associate at the Law Offices of William C. Haynes in Lancaster, PA. J.D, Pennsylvania State University – Dickinson School of Law; B.A. in English and American Literature, Hofstra University. The author wishes to express her thanks to Robert E. Rains, for his invaluable aid in the writing and publication of this article, and to Mark Podvia, for his research assistance.

1. United States Public Health Services, *2004 Surgeon General's Report, The Health Consequences of Smoking: A Report of the Surgeon General, Executive Summary*, 14, available at http://www.cdc.gov/tobacco/sgr_2004/pdf/executivesummary.pdf (last visited November 7, 2004) [hereinafter "2004 Surgeon General's Report"].

2. *Id.* at Tbl 1.1. The 2004 Surgeon General's Report identifies the following diseases found to be caused by, or substantially linked to, smoking: cancers, including bladder cancer, cervical cancer, esophageal cancer, kidney cancer, laryngeal cancer, leukemia, lung cancer, oral cancer, pancreatic cancer, and stomach cancer; cardiovascular diseases, including abdominal aortic aneurysm, atherosclerosis, cerebrovascular disease, and coronary heart disease; respiratory diseases, including chronic obstructive pulmonary disease, pneumonia, respiratory effects in utero including reduced infant lung function, respiratory effects in childhood and adolescence including impaired lung growth, early onset lung function decline, coughing, phlegm, wheezing, and asthma related symptoms, respiratory effects in adults, including premature onset of and accelerated lung function decline, coughing, phlegm, wheezing, dyspnea, and poor asthma control; reproductive effects, including sudden infant death syndrome, reduced fertility in women, fetal growth restrictions and low birth weight, and pregnancy

forefront of American tobacco consumption in the 1920's; consumption increased over the next twenty-five years, saw a large increase during World War II among both men and women, and hit its high point in the 1960's at a rate of over 4,000 cigarettes consumed per adult per year.³ Temporary declines in consumption patterns have been observed over the years, generally coinciding with times of increased public concern over the health hazards of smoking.⁴ However, recent data suggests that current smoking prevalence is highest among men, persons living below the poverty level, and persons who have dropped out of high school.⁵

It has also been suggested, by Administrative Law Judge John Marshall Meisburg Jr., that "smoking and disability" – meaning the determination of disability for purposes of federal disability benefits under Title II (Social Security Disability Insurance benefits,

complications such as premature rupture of the membranes, placenta previa, placental abruption, preterm delivery and shortened gestation; and other impairments, including nuclear cataract, diminished health status/morbidity, hip fractures, low bone density, and peptic ulcer disease. *Id.*

3. MATTHEW BENDER & CO., ATTORNEY'S TEXTBOOK OF MEDICINE, pt.209.11 (3rd. ed. 2004) [hereinafter "Attorney's Textbook of Medicine"].

4. *Id.*

Temporary declines in U.S. per capita cigarette consumption were observed in the intervals from 1953 to 1954, in 1964, and from 1968 to 1970; available data suggest that these figures represent primarily individuals' cessation of the smoking habit. It is believed that the declines in consumption may have coincided with periods of increased publicity concerning the health hazards of cigarette smoking – e.g., the first report of the Advisory Committee to the Surgeon General (1964), The Federal Cigarette Labeling and Advertising Act. . . and The Public Health Cigarette Smoking Act.

Id., citing Federal Cigarette Labeling and Advertising Act, Pub. L. 89-92, 79 Stat. 282 (1966); Public Health Cigarette Smoking Act, Pub. L. 91-222, 84 Stat. 87 (1970).

5. *Id.* at 209.13, citing the Social Security Act.

The smoking prevalence of men (27.7%) was significantly higher than that of women (22.5%) . . . Persons living below the poverty level had higher smoking prevalences (*sic*) (32.1%) than those living at or above the poverty level (23.8%). Among individuals with 9 years of education, prevalences varied inversely with educational level. The highest smoking prevalence was observed in men who had dropped out of high school (42.1%).

Attorney's Textbook of Medicine, *supra* note 3, at pt.290.13.

hereinafter “SSD”) and Title XVI (Supplemental Security Income benefits, hereinafter “SSI”) of the Social Security Act (hereinafter “the Act”) – “go hand in hand” – meaning that a substantial portion of disability claimants are also smokers.⁶ This suggestion that “smoking and disability are inextricably intertwined”⁷ raises questions about the level of impact tobacco abuse has on the determination of disability for purposes of SSI and SSD, and how the courts treat claimants who abuse tobacco.

There are several potential places in the disability evaluation process where current, continued tobacco use could result in a denial of benefits; in his most recent article discussing the issue, Judge Meisburg states that “[u]nder the law, disability benefits can and should be denied . . .” to these claimants, largely because such denials would have a “public policy salutary effect” by saving Social Security trust fund money and motivating current smokers to quit.⁸ Do the courts agree with such a course of action? Does experience with the treatment of other drugs under the Social Security Act support the public policy arguments articulated by Judge Meisburg for denying benefits to smokers?

This article will address these and other questions by examining the law involved in the determination of disability when tobacco abuse is involved. Part II of this article will provide an overview of the Social Security Act and the sequential evaluation process used to determine whether a claimant is disabled such that he or she may receive federal benefits under the Act. This section will highlight potential problem areas in the process where tobacco abuse could result in a denial of benefits, particularly the two areas addressed by Judge Meisburg: the requirement that claimants must follow prescribed medical treatment and the Drug Addiction and Alcoholism (“DA&A”) analysis.⁹

Part III will examine issues that arise when the argument is made that continued tobacco abuse constitutes a failure to follow prescribed medical treatment. Specifically, Part III will discuss how the courts have handled the issues of “prescribed” treatment versus

6. The Hon. John Marshall Meisburg, Jr., *Smoking, Nicotine, and Disability: A 2003 Update*, FED. LAW. Sept. 2003, 36.

7. *Id.* at 40.

8. *Id.*

9. *Id.* at 36-40.

“suggested” treatment, whether addiction to tobacco constitutes good cause for failure to stop smoking, and whether the required showing that cessation of smoking would restore the claimant to health. This section concludes that, while there is a split in the circuits on these issues, several of the U.S. Courts of Appeals have adopted a more lenient treatment of smokers than that suggested by Judge Meisburg, and have placed a relatively heavy burden of proof on the finder of fact.

Part IV of this article will provide a look at the details of the DA&A analysis as the courts have applied it. This section then argues that, contrary to the position of Judge Meisburg, nicotine abuse may not fall under the DA&A analysis. Part IV will also address the particular public policy justifications articulated by Judge Meisburg as to why DA&A analysis should apply to smokers, concluding that past experience relating to the efficacy of the DA&A analysis suggests that application of the analysis to smokers would not have the “public policy salutary effect” suggested by Judge Meisburg.¹⁰

Finally, Part V offers a summary of and conclusions about the current state of the law with respect to disability benefits and tobacco abuse. This section argues that while it is *possible* to deny benefits to smokers based on tobacco abuse, a blanket rule *denying* benefits simply because the claimant is a smoker is unwarranted by the current state of the law and may not be the wisest course of action in terms of beneficial public policy.

II. THE SOCIAL SECURITY ACT, THE SEQUENTIAL EVALUATION, AND POTENTIAL PROBLEM AREAS

A. *Relevant Amendments to the Social Security Act*

In 1956, Congress created a program of disability insurance, or the SSD, by amending the Social Security Act, which provided for retirement programs and survivor’s benefits.¹¹ As originally passed,

10. *Id.*

11. For a concise overview of the evolution of the Social Security Act, with an emphasis on the history of the DA&A analysis, see Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOK. L. REV. 185, 187-93; see also Sharon R. Hunt & Jim Baumohl, *Drink, Drugs, and Disability: An Introduction to*

the 1956 SSD program paid benefits to those persons between the ages of fifty and sixty-five who had paid into the system based on their earnings, and were no longer able to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration."¹² SSD coverage was expanded by later amendments to provide benefits to dependents¹³ and to remove the lower age restriction.¹⁴

Congress further supplemented these programs in 1972 with the creation of SSI, specifically designed to aid individuals in poverty that were too disabled to work.¹⁵ Under this program, individuals that were found to be disabled under the five-step sequential evaluation process explained in detail below could receive a monthly cash benefit.¹⁶ In 1989, the Act was further amended to recognize alcoholism and addiction as qualifying impairments under the sequential evaluation; however, recipients of SSI benefits based on such impairments were subject to certain limitations, such as the requirement that they participate in treatment programs and that they designate a representative payee to manage their benefits.¹⁷

In 1994, due to rising costs for the SSI program and public concern over the growing number of addicts receiving federal benefits,¹⁸ Congress passed the Social Security Independence and Program Improvements Act, which placed a thirty-six month time limit on benefits available to alcoholics and addicts, expanded the scope of the 1989 limitations to encompass both SSI and SSD

the Controversy, 30 CONTEMP. DRUG PROBS. 9 (reviewing the history of the treatment of drug addicts and alcoholics under the Act and the politics underlying the creation of the DA&A analysis).

12. Social Security Act, 42 U.S.C. § 423(d) (1956).

13. Social Security Amendments of 1958, Pub. L. No. 85-840, 72 Stat. 1013 (1958).

14. Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924 (1960).

15. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972).

16. *Id.*

17. 20 C.F.R. 404(P)(1)(A) § 12.09 (1989); *see also* Stevenson, *supra* note 11, at 188-89, Hunt, *supra* note 11, at 31.

18. Stevenson, *supra* note 11, at 190-91; *see also* Hunt, *supra* note 11, at 37-47.

benefits, and provided that failure to comply with treatment would result in the suspension of benefits.¹⁹ However, the number of beneficiaries continued to grow;²⁰ the Congressional explanation for this growth was that federal benefits provided an incentive for alcoholics or addicts *not* to seek proper treatment.²¹

In order to rectify this perceived problem with the then-existing benefits systems, Congress passed the Contract with America Advancement Act of 1996, which denied SSI or SSD benefits to claimants whose addiction is “a contributing factor material to their disability.”²² This standard, discussed in detail below, essentially requires the finder of fact in a benefits determination to decide whether the claimant would still be disabled within the meaning of the Act but for the alcohol abuse or drug addiction.

B. The Sequential Evaluation

In order to qualify for SSD benefits, the claimant must meet the insured status requirements,²³ be less than sixty-five years of age, and be under a “disability,” as defined by the Act.²⁴ In order to qualify for SSI benefits, a claimant must be a resident of the United States with limited resources, and be over the age of sixty-five, blind, or qualify as “disabled” under the Act.²⁵ In the case of both SSD and

19. Social Security Independence and Program Improvement Act of 1994, Pub. L. No. 103-296, 108 Stat. 1464 (1994).

20. Hunt, *supra* note 11, at 27, Fig.1 (chart demonstrating the growth in the SSI DA&A rolls from December 1975 through June 1996).

21. Stevenson, *supra* note 11, at 191.

22. Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat. 852 (1996); *see also* Stevenson, *supra* note 11, at 192.

23. *See* 20 C.F.R. § 404.130 (2004) (explaining the rules for determining disability insured status).

24. *See e.g.*, Flint v. Sullivan, 951 F.2d 264, 267 (10th Cir. 1991).

25. 20 C.F.R. § 416.202 (2005). This regulation sets out other requirements for eligibility. It also restates the thirty-six month limitation on benefits for alcoholics and addicts eligibility requirements put in place by the Social Security Independence and Program Improvement Act of 1994:

You are disabled, drug addiction or alcoholism is a contributing factor material to the determination of disability, and you have not previously received a total of 36 months of Social Security benefit payments when appropriate treatment was available or

SSI benefits for adults,²⁶ a five-step sequential evaluation process is used to determine whether a claimant is disabled.²⁷

Step one in the sequential evaluation process is determining whether the claimant is currently engaged in substantial gainful activity (SGA).²⁸ This is defined as work that involves "doing significant and productive physical or mental duties," and is "done (or intended) for pay or profit."²⁹ If the claimant is engaged in a

36 months of SSI benefits on the basis of disability where drug addiction or alcoholism was a contributing factor material to the determination of disability.

20 C.F.R. § 416.202(e) (2005), citing Social Security Independence and Program Improvement Act of 1994, *supra* note 19.

26. The determination of disability in children for SSI purposes is made using a three-step sequential evaluation process that asks: (1) if the child is engaged in substantial gainful activity, (2) has an impairment that is severe and meets the durational requirement, and (3) whether that impairment meets, medically equals, or functionally equals a listing in the Listing of Impairments. 20 C.F.R. § 416.924 (2005), citing 20 C.F.R. pt.404, subpt.P, app.1 (pt.B). It is beyond the scope of this article to consider in detail the impact of tobacco abuse in disability determinations for children. However, the issue has relevance because the latest Surgeon General's Report shows that, while the percentage of current minor smokers has been reduced since 1997, the trend in reduction has slowed appreciably. Tobacco abuse has also been linked to many diseases that affect children, both before they are born and as they grow. *See* 2004 Surgeon General's Report, *supra* note 1, at 14 (for statistics on tobacco use in minors) and Tbl.1.1 (for description of diseases in children linked to tobacco abuse). However, the Social Security Administration Programs Operating Manual System (hereinafter "POMS") states that, for the purposes of invoking the application of the DA&A analysis, "[m]edically determinable substance use disorders . . . [d]o not include medical conditions that arise from a mother's use of alcohol or drugs during pregnancy (e.g., fetal alcohol syndrome or "crack baby" cases)," thereby eliminating several classes of diseases recognized by the Surgeon General as caused by tobacco abuse. Social Security Administration Policy Site, Programs Operating Manual, § DI 90070.050(C)(2), available at <http://policy.ssa.gov/poms.nsf/lnx/0490070050!opendocument> (last visited Oct. 25, 2005).

27. *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); *see also* 20 C.F.R. §§ 404.1520, 416.920 (2005) (regarding SSD and SSI determinations, respectively).

28. *Yuckert*, 482 U.S. at 141; *see also* 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

29. 20 C.F.R. §§ 404.1510, 416.910 (2005) (regarding SSD reference determinations and SSI determinations, respectively).

SGA, he or she is not disabled and the evaluation ceases.³⁰ However, if the claimant is not engaged in a SGA, the evaluation proceeds to step two; at this point, the fact finder must determine whether the claimant has a severe impairment or combination of impairments that meets the durational requirement.³¹

If the finder of fact determines that the claimant has a severe impairment(s), step three of the sequential evaluation asks whether that impairment(s) meets or equals any impairment in the Listing of Impairments;³² if a claimant has such an impairment, it warrants a finding of "disabled."³³ If the claimant cannot show such an impairment, the inquiry moves to step four, where the claimant's residual functional capacity to do work activity is assessed³⁴ and used to determine whether the claimant can still do his or her past relevant work.³⁵ If the claimant can return to his or her past relevant work, a

30. 20 C.F.R. §§ 404.1520(b), 416.920(b) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

31. *Yuckert*, 482 U.S. at 141; *see also* 20 C.F.R. §§ 404.1520, 416.920(a)(4)(ii) (2005) (regarding SSD reference determinations and SSI determinations, respectively). The durational requirement is as follows: "Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of *at least 12 months*." 20 C.F.R. §§ 404.1509, 416.909 (2005) (regarding SSD reference determinations and SSI determinations, respectively) (emphasis added). In defining the required level of severity, the SSA regulations state that an impairment is *not* severe "if it does not significantly limit your physical or mental ability to do basic work activities" meaning "the abilities and aptitudes necessary to do most jobs." 20 C.F.R. §§ 404.1521, 416.921 (2005) (regarding SSD reference determinations and SSI determinations, respectively).

32. 20 C.F.R. pt.404, subpt.P, app.1 (pt. A). Part A of the Listings deals with impairments in adults and is divided into the following fourteen categories of impairments: Musculoskeletal System (1.00), Special Senses and Speech (2.00), Respiratory System (3.00), Cardiovascular System (4.00), Digestive System (5.00), Genito-Urinary System (6.00), Hemic and Lymphatic System (7.00), Skin (8.00), Endocrine System (9.00), Multiple Body Systems (10.00), Neurological (11.00), Mental Disorders (12.00), Neoplastic Diseases, Malignant (13.00), Immune System (14.00). Part B of the Listings deals with impairments in children and is divided into similar categories of impairments.

33. 20 C.F.R. §§ 404.1520(d), 416.920(d) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

34. 20 C.F.R. §§ 404.1520(e), 416.920(e) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

35. 20 C.F.R. §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

finding of "not disabled" will be made.³⁶ The final step in the sequential evaluation is for the finder of fact to determine whether the claimant could make the adjustment to any other work, taking into consideration the claimant's residual functional capacity, age, education, and past work experience.³⁷ If the claimant would be unable to make the adjustment, he or she is "disabled" for SSI and SSD purposes.³⁸

The claimant has the burden of proof at steps one through four. As detailed above, if the claimant fails to meet the burden of proof at any of these steps, except at step three, a finding of "not disabled" will be entered. The burden then shifts to the Commissioner of the Social Security Administration to show that the claimant is not disabled.³⁹

C. Potential Problem Areas with Respect to Continued Tobacco Abuse

Under the current federal benefits system, there are two major potential areas where continued, current tobacco abuse could enter into the disability determination and result in the denial of benefits. First, a finding that the claimant is not disabled may be entered if, at any time, the finder of fact determines that the claimant has failed in the duty to follow prescribed medical treatment if such treatment could restore the claimant to the work force.⁴⁰ In short, the argument can be made that claimant's continued tobacco abuse after their doctor has advised them to stop using tobacco can be seen as exacerbating the debilitating condition(s), such that if the claimant were to stop, they would no longer be disabled.

36. 20 C.F.R. §§ 404.1520(f), 416.920(f) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

37. 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v) (2005) (regarding SSD reference determinations and SSI determinations, respectively); *see also* Williams v. Bowen, 844 F.2d 748, 850-52 (10th Cir. 1988).

38. 20 C.F.R. §§ 404.1520(g), 416.920(g) (2005) (regarding SSD reference determinations and SSI determinations, respectively).

39. Thompson v. Sullivan, 987 F.2d 1482, 1487 (10th Cir. 1993).

40. *See infra* notes 43-46 and accompanying text; *see also* 20 C.F.R. §§ 404.1530, 416.930 (2005) (regarding SSD reference determinations and SSI determinations, respectively).

Second, it is possible that nicotine abuse could fall under the DA&A analysis.⁴¹ The DA&A analysis functions almost as a “sixth step” in the sequential evaluation. This allows the finder of fact to determine that claimants are not disabled even if they have successfully passed the previous five steps, if the claimants’ alcoholism or addiction is a contributing factor material to the disability.⁴²

III. FAILURE TO QUIT AS FAILURE TO FOLLOW PRESCRIBED MEDICAL TREATMENT

A. The Duty to Comply as a Per Se Rule

The current Social Security Administration (SSA) regulations provide that the finder of fact in a claim for disability benefits may make a finding of “not disabled” if the claimant has breached the duty to comply with prescribed medical treatment.⁴³ More specifically:

41. See *supra* note 22 and accompanying text; see also *infra* notes 95-133 and accompanying text.

42. 20 C.F.R. §§ 404.1535(a), 416.935(a) (2005) (regarding SSD reference determinations and SSI determinations, respectively). “If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.” *Id.* (emphasis added). This language suggests that the DA&A analysis is applied to the case only after the completion of the five-step sequential evaluation. However, there is case law which suggests that even though the DA&A analysis arguably functions as a sixth step, the Contract with America Advancement Act did not specifically alter the mandated five-step sequential evaluation and thus it is inappropriate to refer to the DA&A analysis as a “sixth step” in the evaluation. See, e.g., *Doughty v. Apfel*, 245 F.3d 1274, 1280 (11th Cir. 2001); *Brown v. Apfel*, 192 F.3d 492, 498 (5th Cir. 1999). However, several courts have held that application of the DA&A analysis is premature unless a finding of “disabled” has been made under the five-step sequential evaluation. See, e.g., *Bustamante v. Massanari*, 262 F.3d 949, 954-55 (9th Cir. 2001), *Drapeau v. Massanari*, 255 F.3d 1211, 1214-15 (10th Cir. 2001). For purposes of this article, I will refer to the DA&A analysis as a sixth step because I find it to be a useful way to understand the interplay between the five-step sequential evaluation and DA&A analysis.

43. 20 C.F.R. §§ 404.1530, 416.930 (2005) (regarding SSD reference determinations and SSI determinations, respectively).

In order to get benefits, you must follow treatment *prescribed by your physician* if this treatment can *restore your ability to work* If you do not follow the prescribed treatment without a *good reason*, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.⁴⁴

As noted by Judge Meisburg, federal courts have held that a claimant's "failure to stop smoking cigarettes against the advice of a treating physician can constitute the failure to follow prescribed treatment under SSA regulations."⁴⁵ Case law from the Sixth Circuit, the Eighth Circuit, and district courts following Eighth Circuit precedent appears to support this *per se* rule, holding that the failure to quit smoking constitutes the failure to follow prescribed treatment whenever this is even mentioned in the claimant's medical records by a treating physician.⁴⁶ However, a closer look at these cases reveals that, in the majority, the failure to stop smoking was merely one factor supporting the decision to deny benefits, not the sole basis of the denial.⁴⁷ This suggests that the precedent favoring a *per se* rule

44. *Id.* (emphasis added).

45. Meisburg, *supra* note 6, at 38.

46. See e.g., *Kisling v. Chater*, 105 F.3d 1255 (8th Cir. 1997); *Higgins v. Callahan*, 983 F. Supp. 865 (E.D. Mo. 1997); *Meeks v. Apfel*, 993 F. Supp. 1265 (W.D. Mo. 1997); *Roth v. Shalala*, 45 F.3d 279 (8th Cir. 1995); *Sias v. Sec'y of Health & Human Servs.*, 861 F.2d 475, 480 (6th Cir. 1988); *Bledsoe v. Bowen*, 1988 U.S. Dist. LEXIS 15130 (W.D. Mo. 1988).

47. *Kelley v. Callahan*, 133 F.3d 583, 589 (8th Cir. 1998); *Kisling*, 105 F.3d at 1257 (holding that Commissioner's determination that claimant's physical and mental impairments do not inhibit her ability to perform her past relevant work was supported by medical evidence in the record, the fact that the claimant failed to quit smoking despite advice from her doctor, and the court's proper assessment of witness credibility); *Higgins*, 983 F. Supp. at 871 (holding that failure to stop smoking mitigates against finding of disability); *Meeks*, 993 F. Supp. at 1276 (holding that plaintiff's failure to lose weight, exercise, and stop smoking constituted a failure to follow prescribed treatment, however, the claim was denied based on the court's determination of claimant's credibility as to the severity of his impairments); *Roth*, 45 F.3d at 282 (claimant was advised to begin physical reconditioning and stop smoking; the court found that he had failed to follow prescribed treatment because he did not heed limit on lifting, did not exercise, and did not take any medication); *Sias*, 861 F.2d at 480 (failure to quit smoking was one factor supporting the court's determination of not disabled); *Bledsoe*, 1988 U.S. Dist. LEXIS 15130 at 13 (court determined that claimant was not disabled

can be reconciled with the more lenient reading of the “prescribed treatment” rule that is more widely used in other circuits, as described in detail below.

B. The Four-Factor Test for Failure to Comply

Evidence in a claimant’s records that the claimant’s treating physician has indicated that smoking cessation is warranted need not lead directly to a denial of benefits *per se*.⁴⁸ A four-part test has been developed by courts reviewing a denial of benefits based on failure to follow prescribed treatment: (1) the treatment must have been prescribed, (2) the treatment must have been refused, (3) the refusal must have been without justifiable excuse, and (4) the treatment at issue should be expected to restore the claimant’s ability to work.⁴⁹ The burden of proof is on the finder of fact to demonstrate that substantial evidence⁵⁰ in the record supports each factor.⁵¹ The application of this test raises key issues at every step which suggest that denial of benefits to all smokers based on the “prescribed treatment” regulations is not a blanket rule and is not the approach favored by several circuits.⁵²

based upon credibility determination, medical evidence in the record, claimant’s failure to stop smoking, and his own observations of the claimant at the hearing).

48. Judge Meisburg’s 2003 article does briefly address the ideas of “prescribed” versus “suggested” and addiction as good cause; however, he tends to give short shrift to these ideas and seems to downplay the body of case law that is more favorable to claimants who are also smokers. Meisburg, *supra* note 6, at 38-39.

49. *Weakley v. Heckler*, 795 F.2d 64, 66 (10th Cir. 1986); *Jones v. Heckler*, 702 F.2d 950, 953 (11th Cir. 1983).

50. “‘Substantial evidence’ is ‘such relevant evidence as a reasonable mind might accept to support a conclusion.’ It may be less than a preponderance of the evidence, but must be more than a mere scintilla.” *Ingram v. Barnhart*, 72 F. App’x 631, 633 (9th Cir. 2003) (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)).

51. See e.g., *Geubelle v. Barnhart*, No. 02-1297-WEB, 2003 WL 22853100 (D. Kan. Sept. 26, 2003); *Carothers v. Heckler*, 627 F. Supp. 301, 304 (W.D.N.C. 1985); *Weakley*, 795 F. 2d 66.

52. See *infra* notes 52-81 and accompanying text.

1. “Prescribed” v. “Suggested”

As stated in the SSA regulations, the finder of fact may only make a finding of “not disabled” when the claimant has failed to comply with *prescribed* medical treatment without good cause.⁵³ This language raises the question of what constitutes “prescribed treatment,” as laid out in the first factor of the test stated above.⁵⁴

The Sixth Circuit has held that treatment which is merely suggested or recommended does not constitute prescribed treatment.⁵⁵ In *Harris v. Heckler*, the Sixth Circuit held that treatment must be *ordered* by a treating physician to constitute prescribed treatment; if the treatment is not ordered it is characterized as a recommendation.⁵⁶ This distinction was more clearly defined by the Tenth Circuit, which has held that “[r]ecommendations, suggestions, and abstract opinions are not enough” to constitute prescribed treatment under the Social Security regulations.⁵⁷ This approach has been applied by the First and Eleventh Circuits, and was recently applied by the District Court for the Northern District of Alabama.⁵⁸ The result is that with respect to the first factor, to satisfy the burden of proof, the finder of fact must show that substantial evidence in the record indicates that cessation of smoking was ordered, not merely recommended or suggested, to rise to the level of prescribed treatment which invokes the duty of compliance.

2. Role of Attempts to Quit and Addiction as “Good Reason”

To deny benefits, steps two and three of the test articulated above

53. See *supra* note 43 and accompanying text.

54. See *supra* note 48 and accompanying text.

55. *Harris v. Heckler*, 756 F.2d 431, 435 n.2 (6th Cir. 1985). The dissent in *Harris* argues that by “distinguishing a ‘suggested course of treatment’ from a ‘prescribed course of treatment’” the majority “extols form over substance,” however, *Harris* is still good law in the Sixth Circuit. *Id.* at 439 n.3 (Wellford, J., dissenting).

56. *Harris*, 756 F.2d at 435 n.2.

57. *Teter v. Heckler*, 775 F.2d 1104, 1107 (10th Cir. 1985).

58. *Seals v. Barnhart*, 308 F. Supp. 2d 1241 (N.D. Ala. 2004); *Jones v. Heckler*, 702 F.2d 950 (11th Cir. 1983); *Schena v. Sec’y of Health & Human Servs.*, 635 F.2d 15 (1st Cir. 1980).

require the finder of fact to show that the claimant refused prescribed treatment and that such refusal was without justification.⁵⁹ Assuming that an order to stop smoking was given such that it constituted “prescribed treatment,” the courts have considered attempts to quit smoking in relation to the second factor of the evaluation in relation to “refusal” of treatment.⁶⁰

In *O'Donnell v. Barnhart*, the Eighth Circuit held that when the claimant has made several attempts to stop smoking, with the help of prescription medications, the failure to stop smoking as failure to follow prescribed treatment will not undermine her credibility.⁶¹ The Tenth Circuit has also adopted this approach with respect to attempts to stop smoking, holding that the failure to stop smoking after cessation has been advised by a treating physician does not militate against a finding of disability where the record shows that the claimant has made several attempts to quit and has significantly cut back on his smoking as a result of medical advice.⁶² These cases suggest that attempts to quit may mitigate against a finding of refusal of treatment.

This standard was recently adopted and applied by the District Court for the Northern District of Alabama, holding that since the record contained evidence of several attempts to stop smoking, a “willful refusal” to follow treatment could not be assumed from “a

59. *Supra* note 48 and accompanying text.

60. *Infra* notes 60-63 and accompanying text.

61. *O'Donnell v. Barnhart*, 318 F.3d 811, 819 (8th Cir. 2003). Continued tobacco abuse as a failure to follow prescribed medical treatment could enter into the fact finder's determination of the claimant's credibility, especially in determining credibility of the claimant's subjective complaints of disabling pain or shortness of breath. The circuits are split on whether it is proper for the finder of fact to consider tobacco abuse as non-compliance in making a credibility determination in such cases. *Compare* *Shramek v. Apfel*, 226 F.3d 809 (7th Cir. 2000) (holding that it is a misuse of the non-compliance regulation to negatively assess credibility), *and* *Rousey v. Heckler*, 771 F.2d 1065, 1070 (7th Cir. 1985) (holding that it was improper for the ALJ to find incredible claimant's complaints of chest pain because she continued to smoke when the medical evidence in the record did not demonstrate that her chest pain was directly linked to her continued smoking), *with* *McGeorge v. Barnhart*, 321 F.3d 766 (8th Cir. 2003) (holding that non-compliance is a factor in the credibility determination in relation to allegations of shortness of breath).

62. *Knipe v. Heckler*, 755 F.2d 141, 149 n.16 (10th Cir. 1985).

mere failure to accomplish the recommended change.”⁶³ This court overlapped the second and third factors and stated that “[g]uidance in smoking cases can be found in case[s] involving recommendations to lose weight,” holding that the failure to stop smoking, like the failure to lose weight, “[d]oes not constitute a refusal to undertake [a] prescribed course of treatment,” rather there must be something more in the record to show willful refusal without good cause.⁶⁴

With respect to the third factor, justification for the refusal to follow prescribed treatment, the SSA regulations dealing with prescribed treatment provide several examples of what will constitute “good reason” for failure to comply with prescribed treatment.⁶⁵ According to the regulations, good cause may be found if the particular treatment is contrary to the claimant’s religion, if a suggested surgery has been previously performed without success, or if the particular treatment is very risky or would result in amputation of a limb.⁶⁶ Judge Meisburg notes that these regulations do not list addiction as a justification for non-compliance.⁶⁷ However, the regulations merely provide a list of *examples* and state that the finder of fact will consider the claimant’s “physical, mental, educational, and linguistic limitations” when determining good cause.⁶⁸ Based upon this language in the regulations, several courts have suggested that addiction to nicotine⁶⁹ may be a good reason for refusing to stop smoking despite a doctor’s orders.⁷⁰

63. *Seals*, 308 F. Supp. 2d at 1250.

64. *Id.*

65. 20 C.F.R. §§ 404.1530, 416.930 (2005) (with reference to SSD benefits and SSI benefits respectively).

66. *Id.*

67. Meisburg, *supra* note 6, at 39.

68. 20 C.F.R. §§ 404.1530 (2006) (with reference to SSD benefits), 416.930 (with reference to SSI benefits). *See also* Social Security Program Policy Statement: Title II and Title XVI Failure to Follow Prescribed Treatment, SSR 82-59 (1982) (discussing justifications for non-compliance: “The specific reasons listed above [the examples in the regulation] are not all-inclusive as acceptable justifications for refusing to accept prescribed treatment. A full evaluation must be made in each case to determine whether the individual’s reason(s) for failure to follow prescribed treatment is justifiable.”).

69. Judge Meisburg also argues that “there is considerable debate . . . as to whether cigarette smoking is addictive,” Meisburg, *supra* note 6, at 39, however, for purposes of this article it is assumed that nicotine is addictive, as recognized by

Nicotine addiction has been likened to alcohol addiction by several courts, in that continuing to smoke may not be a voluntary decision of the claimant.⁷¹ The Fourth Circuit has stated that allegations of tobacco abuse should be treated in the same manner as allegations of alcohol abuse, and benefits may only be denied on the grounds of continued abuse after a finding has been made that cessation has been prescribed and that “the claimant is able voluntarily to stop.”⁷² Judge Meisburg notes that many of the cases dealing with voluntary ability to stop smoking were decided before the DA&A analysis was put in place in 1996.⁷³ He argues that claiming addiction under the current standards acts as a “double-edged sword,” in that a claimant could perhaps show a good reason for failure to follow prescribed medical treatment but in so doing would also demonstrate an addiction that would subject them to the DA&A analysis.⁷⁴ However, addiction to nicotine has been held to constitute good reason for non-compliance as recently as March 2004,⁷⁵ and, as will be discussed below, it is possible that the DA&A

the Surgeon General, the DSM-IV, and the case law of several circuits. *See e.g.*, 2004 Surgeon General’s Report, *supra* note 1, at 15; AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION 175, 242 (4th ed. 1994) (hereinafter “DSM-IV”); *and* Weaver v. Sec’y of Health & Human Servs., 82-0389-F, 1986 U.S. Dist. LEXIS 26919, at *10 n.5 (D. Mass. 1986) (noting that consensus in medical community is that smoking is addictive).

70. *See e.g.* Seals v. Barnhart, 308 F. Supp. 2d 1241 (N.D. Ala. 2004); Burnside v. Apfel, 223 F.3d 840, 843-44 (8th Cir. 2000); Gordon v. Schweiker, 725 F.2d 231, 236 (4th Cir. 1984); Caprin v. Harris, 511 F. Supp. 589, 590 (N.D.N.Y. 1981).

71. *See e.g.* Seals, 308 F. Supp. 2d at 1251; Carothers v. Heckler, 627 F. Supp. 301, 304 (W.D.N.C. 1985); Gordon, 725 F.2d at 236; Caprin, 511 F. Supp. at 590.

72. Gordon, 725 F.2d at 236.

73. Meisburg, *supra* note 6, at 40 n.7.

74. *Id.* at 39.

75. Seals, 308 F. Supp. 2d at 1251:

Continuing to smoke, however, is often not a voluntary decision, rational or otherwise, of the smoker Breaking an addiction is not a simple matter or rationally deciding to cease the addictive behavior, whether it be smoking, drinking, or drug abuse In the case of nicotine addiction, the mere failure to successfully stop smoking will not support a finding of willful refusal to try. If the plaintiff was unable to stop smoking because she was addicted to nicotine, her noncompliance would not be unjustified.

analysis does not apply to persons addicted to nicotine.⁷⁶ Therefore, it seems reasonable to assume that addiction to nicotine may serve as justification for non-compliance with an order to stop smoking.

3. Restoration to the Work Force

Finally, with respect to the fourth factor of the test articulated above, the finder of fact has the burden of showing by substantial evidence that the treatment at issue could restore the claimant to the work force.⁷⁷ If the finder of fact fails to make this critical finding, or if the finding is not supported by substantial evidence in the record, the claimant may not be denied benefits on the basis of non-compliance.⁷⁸

With respect to this finding, the courts have held that mere improvement of a disabling condition does not necessarily equal an ability to return to work.⁷⁹ Additionally, the finder of fact must make the determination that a claimant could return to work if he or she followed the prescribed treatment based on the "testimony and medical evidence in the record."⁸⁰ In short, the A.L.J. may not "make his own determination regarding the prognosis of recovery . . . when the record [is] devoid of any evidence that [the claimant] could return to work if she quit smoking."⁸¹ The case law dealing with this step four finding shows that a remand to the finder of fact is often warranted due to insufficient evidence to support a finding of not disabled at this step.⁸²

The burden is on the Commissioner to produce evidence of unjustified noncompliance.

76. See *infra* notes 95-111 and accompanying text.

77. See *supra* note 48 and accompanying text. See also *Seals*, 308 F. Supp. 2d at 1251 (quoting *Patterson v. Bowen*, 799 F. 2d 1455, 1460 (11th Cir. 1986)).

78. *Seals*, 308 F. Supp. 2d at 1251.

79. See, e.g., *id.* at 1252; *Weaver*, 1986 U.S. Dist. LEXIS 26919, at *10 n.5; *Rousey v. Heckler*, 771 F.2d 1065, 1069 (7th Cir. 1985); *Corrie v. Schweiker*, No. 81-C-771, 1982 U.S. Dist. LEXIS 11167, at *7 n.5 (N.D. Ill., Mar. 7, 1982).

80. *Rousey*, 771 F.2d at 1069. See also *Weakley v. Heckler*, 795 F. 2d 64, 66 (10th Cir. 1986).

81. *Rousey*, 771 F.2d at 1069.

82. See e.g. *Geubelle v. Barnhart*, No. 02-1297-WEB, 2003 WL 22853100 (D. Kan. Sept. 26, 2003); *Burnside v. Apfel*, 223 F.3d 840, 844 (8th Cir. 2000); *Rousey*, 771 F.2d at 1071.

IV. DA&A ANALYSIS – “STEP SIX” OF THE SEQUENTIAL EVALUATION

A. The DA&A Analysis and the Materiality Determination

The standard for denying benefits to alcoholics and drug addicts under the DA&A analysis is set out in the current SSA regulations, which state: if the finder of fact determines that the claimant is disabled⁸³ and there is medical evidence in the record of drug addiction or alcoholism, the DA&A analysis must be applied to determine whether the claimant would still be disabled but for the addiction or alcohol abuse.⁸⁴ The circuit courts place the burden of proof on the claimant to show that alcoholism or addiction is not a material factor in a Step Six determination under the DA&A analysis.⁸⁵

83. See *supra* note 42 and accompanying text (discussing whether it is necessary for the court to complete the five-step sequential evaluation as a condition precedent before claimant's drug addiction or alcoholism is considered).

84. 20 C.F.R. §§ 404.1530, 416.930 (2005) (with reference to SSD benefits and SSI benefits respectively). Internal SSA operating guidelines laid out in the POMS state that the required medical evidence must be from an acceptable medical source, defined in the POMS as a licensed physician, licensed or certified psychologist, licensed optometrist, licensed podiatrist, or qualified speech-language pathologist. POMS, *supra* note 26, at DI90070.050 (DA&A Material Determinations) and DI22505.003.B.1 (Medical and Other Evidence of an Individual's Impairments). According to these guidelines, the claimant's own statements about whether or not he or she is addicted are considered “evidence” but are never “sufficient and appropriate” to establish an addiction or alcoholism such that the DA&A analysis must be applied. *Id.* at DI90070.050. It should also be noted that the DA&A analysis has withstood challenges to its constitutionality based on the Equal Protection Clause and the Due Process Clause. See e.g. *Ball v. Massanari*, 254 F.3d 817, 824 (9th Cir. 2001) (citing *Mitchell v. Commissioner*, 182 F.3d 272 (4th Cir. 1999)); *Mitchell v. Apfel*, 19 F. Supp. 2d 523, 531 (D.N.C. 1998); *Stengel v. Callahan*, 983 F. Supp. 1154 (N.D. Ill. 1997). For an early overview of the constitutionality of the DA&A analysis, see Nicole Fiocco, *The Unpopular Disabled: Drug Addicts and Alcoholics Lose Benefits*, 49 ADMIN. L. REV. 1007 (1997).

85. See e.g. *Ingram v. Barnhart*, 72 F. App'x 631, 634 (9th Cir. 2003); *Brueggemann v. Barnhart*, 348 F.3d 689, 693 (8th Cir. 2003); *Ball*, 254 F.3d 817; *Doughty v. Apfel*, 245 F.3d 1274 (11th Cir. 2001); *Mittelstedt v. Apfel*, 204 F.3d 847 (8th Cir. 2000); *Brown v. Apfel*, 192 F. 3d 492 (5th Cir. 1999).

The courts have stated that, per the SSA regulations, “The key factor in determining the materiality of [drug addiction or alcoholism] is whether the claimant would still be considered disabled if she stopped using drugs or alcohol.”⁸⁶ Under the SSA regulations, the finder of fact will “evaluate which of [the claimant’s] current physical and mental limitations, upon which we based our current disability determination, would remain if [the claimant] stopped using drugs or alcohol and then determine whether any or all of [the claimant’s] remaining limitations would be disabling.”⁸⁷ This language has been interpreted to include a finding of disability based upon a combination of impairments that would remain and be severe despite drug addiction or alcoholism,⁸⁸ and to require that the finder of fact sufficiently differentiate between “substance abuse contributing to the disability and the disability remaining after the claimant stopped using drugs or alcohol.”⁸⁹

Several courts have held that, in making the materiality determination, one factor to consider is whether the claimant suffers

86. See e.g. *Ingram*, 72 F. App’x 634; *Brueggemann*, 348 F.3d at 693; *Ford v. Barnhart*, 78 F. App’x 825, 830 (3d Cir. 2003). See also 20 C.F.R. § 404.1535(b)(1) (2006) (describing process for SSD determinations):

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(emphasis added); see also § 416.935(b)(1) (2006) (applying same language to SSD determinations).

87. 20 C.F.R. §§ 404.1535(b)(2), 416.935(b)(2).

88. *Ingram*, 72 F. App’x at 635.

89. *Id.* at 636 n.28 (quoting *Sousa v. Callahan*, 143 F.3d 1240, 1245 (9th Cir. 1998)) (emphasis omitted). The court in *Sousa* held that these two categories of disabilities are not mutually exclusive, and that “[j]ust because substance abuse contributes to a disability does not mean that when the substance abuse ends, the disability will too.” *Id.* See also *Frederick v. Barnhart*, 317 F. Supp. 2d 286, 293 (D.N.Y. 2004) (A.L.J. did not determine which of claimant’s disabilities existed independent of her alcohol abuse); *White v. Comm’r of Soc. Sec.*, 302 F. Supp. 2d 170, 174 (D.N.Y. 2004) (A.L.J.’s determination that claimant’s alcoholism was contributing factor to disability lacked substantial evidentiary support).

from a disability *independent* of the drug or alcohol addiction.⁹⁰ The courts have been careful to note that while “drug addiction and alcoholism inevitably contribute” to other impairments, contribution alone “does not establish or even imply materiality.”⁹¹ The Ninth Circuit, in *Lee v. Callahan*, observed that the materiality determination allows the claimant to qualify for benefits under the DA&A analysis if the claimant’s other impairments would prevent the claimant from working regardless of whether those impairments were *originally* caused by the claimant’s alcoholism or drug addiction.⁹² It has also been found insufficient for the finder of fact to simply determine that the claimant’s disabling conditions would improve if the claimant stopped using drugs or alcohol.⁹³

With these considerations in mind, it is the task of the finder of fact, in applying the materiality standard, to determine “whether the claimant’s limitations would rise to the level of disability absent the effects of drugs and alcohol.”⁹⁴ If this process does not result in a clear determination, benefits must be granted.⁹⁵

B. Does Nicotine Abuse Fall Under the DA&A Analysis?

The federal courts have not yet addressed the issue of nicotine abuse under the DA&A analysis. In arguing that the DA&A analysis should be applied to smokers, Judge Meisburg relies on the SSA Programs Operating Manual System (POMS) to bring smokers under

90. *See, e.g., Lee v. Callahan*, 133 F. 3d 927, 1998 U.S. App. LEXIS 1462 (9th Cir. 1998); *Stengel*, 983 F. Supp. at 1165; *Jones v. Apfel*, 997 F. Supp. 1085 (N.D. Ind. 1997).

91. *Ingram*, 72 F. App’x 637; *see also Frederick*, 317 F. Supp. 2d at 293; *Holmes-Lee v. Barnhart*, No. 00-4144-JAR, 2002 U.S. Dist. LEXIS 19331 (D. Kan. Oct. 3, 2002).

92. *Lee*, 1998 U.S. App. LEXIS 1462, at *5. The decision of the Ninth Circuit in *Lee* was not designated for publication, which may place limits upon its citation value. *See also, generally*, Ann K. Wooster, Annotation, *Validity, Construction, and Application of “Material Contributing Factor” Test under § 105 of the “Contract with America Advancement Act of 1996,” 42 U.S.C.A. § 423(d)(2)(C), in Social Security Disability Cases*, 151 A.L.R. FED. 533 (1999).

93. *Frederick*, 317 F. Supp. 2d at 293.

94. *Holmes-Lee*, 2002 U.S. Dist. LEXIS 19331, at *19.

95. *Bruggemann*, 348 F.3d at 695.

the analysis.⁹⁶ The POMS states that, for purposes of the DA&A analysis, medically determinable substance use disorders which would be subject to the analysis “[a]re medical conditions described as ‘substance dependence’ and ‘substance abuse’ disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*.”⁹⁷ The DSM-IV includes nicotine abuse as a class of substance abuse disorders and states that nicotine dependence can develop with use of all forms of tobacco or prescription medications, such as nicotine gum or the nicotine patch.⁹⁸ Therefore, Judge Meisburg concludes that under the POMS nicotine addiction constitutes a drug addiction subject to the DA&A analysis.⁹⁹

However, the Contract with America Advancement Act of 1996 does not specifically state which drug addictions will qualify under the DA&A analysis, and the terms “drug,” “drug addiction,” and “substance use disorder” are not defined anywhere in the Act as a whole or in the SSA regulations.¹⁰⁰ Additionally, the legislative history of the Contract with America Advancement Act makes no mention of nicotine or tobacco as “drugs” that were being considered when this legislation was proposed.¹⁰¹ Four hearings were held before various committees of the 104th Congress dealing specifically with the DA&A provisions of the Contract with America Advancement Act of 1996: *Problems in the Social Security Disability Programs: The Disabling of America?*;¹⁰² *Rising Costs of Social Security’s Disability Programs*;¹⁰³ *Growth of the*

96. Meisburg, *supra* note 6, at 37.

97. POMS, *supra* note 26, at DI90070.050C.2.

98. DSM-IV, *supra* note 68, at 175,242.

99. Meisburg, *supra* note 6, at 37.

100. Contract with America Advancement Act of 1996, Pub. L. No. 104-121, § 105, 110 Stat. 847, 852-55 (1996).

101. See generally Contract with America Advancement Act of 1996, 104 Cong. Info. Serv. Legis. Hist. P.L. 121 (1996) (providing a summary of the materials included in the legislative history of the Contract with America Advancement Act of 1996).

102. *Problems in the Social Security Disability Programs: The Disabling of America?: Hearing before the Senate Comm. on Aging*, 95 Cong. Info. Serv. S. 1418 (1995).

103. *Rising Costs of Social Security’s Disability Programs: Hearing before the Senate Comm. on Finance*, 95 Cong. Info. Serv. S. 36147 (1995).

Supplemental Security Income Program,¹⁰⁴ and *Managing the Social Security Disability Insurance Program*.¹⁰⁵ In fact, the only reference made to smoking in the legislative history seems to indicate that persons who use tobacco and suffer from related disabilities were not included in the proposed class of drug addicts that would be denied SSI or SSD benefits as a result of the Contract with America Advancement Act of 1996:

Although it is certainly true that addicts played a major role in the development of their disorder, the same can be said for a number of other medical conditions for which we do not deny individuals coverage for treatment. The smoker who develops cancer of the lung or a heart attack, the diabetic whose lack of exercise and increased use of refined carbohydrates leads to an exacerbation of his diabetes, the hypertensive patient who fails to take his hypertensive medication, are all treated very differently by the medical and political system than the addict¹⁰⁶

When a statute is ambiguous on its face as to a particular issue, the agency charged with administering that statute may promulgate regulations that, if reasonable, will be entitled to deference by the courts in resolving the ambiguous issue.¹⁰⁷ Agency interpretations other than regulations which are not subject to the requirements of

104. *Growth of the Supplemental Security Income Program: Hearing before the Senate Comm. on Finance*, 96 Cong. Info. Serv. S. 36118 (1995).

105. *Managing the Social Security Disability Insurance Program: Hearing before the House Comm. on Ways and Means*, 96 Cong. Info. Serv. H. 7817 (1995).

106. *Growth of the Supplemental Security Income Program: Hearing before the Senate Comm. on Finance*, *supra* note 103 (statement of Herbert D. Kleber, M.D., Executive Vice President and Medical Director, Center on Addiction and Substance Abuse, Columbia University Senate Finance Supplemental Security Income Program).

107. *Chevron U.S.A. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984).

the Administrative Procedures Act¹⁰⁸ – such as interpretations in opinion letters, policy statements, agency manuals, and enforcement guidelines – “lack the force of law” and “do not warrant *Chevron*-style deference.”¹⁰⁹ The Supreme Court has held that the POMS is an administrative interpretation only, not the product of formal rulemaking; the POMS therefore lacks the force of law and is not binding on the SSA.¹¹⁰

Agency interpretations that do not warrant *Chevron*-style deference are only “entitled to respect” by the court to the extent that those interpretations have the power to persuade.¹¹¹ Circuit courts applying this standard to the POMS have held that the court will affirm the agency’s interpretation of its own regulations unless the SSA interpretation as enunciated in the POMS is “arbitrary, capricious, or contrary to the law.”¹¹² In short, these cases suggest that application of the DA&A analysis to claimants who are addicted to nicotine is not a foregone conclusion simply because the POMS brings nicotine under the analysis; the issue is open to consideration

108. Administrative Procedure Act, 5 U.S.C. §§ 551 *et seq.* and §§ 701 *et seq.* (2004) (hereinafter “APA”).

109. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000). For a discussion of whether the SSA is required to publish provisions of the POMS in the Federal Register pursuant to the APA, see *Powderly v. Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983) (holding that provisions of the claims manual at issue in the claim were not “substantive rules” such that the APA requires publication in the Federal Register; rather, the provisions were classified as “interpretive rules” – which are exempt from the publication requirement – because the provisions did not change existing law or policy, or remove any previously existing rights of social security recipients, but only explained what the Act and the regulations already provided).

110. *Wash. State Dep’t of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 386 (2003); *Schweiker v. Hansen*, 450 U.S. 785, 790 (1981).

111. *Christensen*, 529 U.S. 587, (citing *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944)).

112. *Neikirk v. Massanari*, 13 F. App’x. 847, 849 (10th Cir. 2001) (citing *McNamar v. Apfel*, 127 F.3d 764, 766 (10th Cir. 1999)). See also *Ingram v. Barnhart*, 72 F. App’x. 631, 636 n.30 (9th Cir. 2003); *Henningson v. Dir, OWCP, United States DOL*, 1999 U.S. App. LEXIS 22420 (10th Cir. 1999); *Davis v. Sec’y of Health & Human Servs.*, 867 F.2d 336, 340 (6th Cir. 1989); *Evelyn v. Schweiker*, 685 F.2d 351, 352 (9th Cir. 1982). For two recent applications of this standard by district courts, see *Finan v. Barnhart*, 327 F. Supp 2d 1303, 1307 (D. Kan. 2004); *Raymond v. Barnhart*, 214 F. Supp 2d 188 (D.N.H. 2002).

by the courts under the standards articulated above, and the courts have yet to address this particular issue.

B. Public Policy Arguments Related to Treatment of Nicotine under the DA&A Analysis

Assuming that nicotine addiction falls under the DA&A analysis, Judge Meisburg argues that the denial of benefits to claimants on the grounds that nicotine addiction is material to the disabling condition would have “an important public policy salutary effect.”¹¹³ Specifically, Judge Meisburg argues that such denials would serve to “educate thousands of disability claimants as to the cause of their diseases and will motivate them to quit smoking.”¹¹⁴ However, the history of the public policy effects of the DA&A analysis with respect to other drug addictions does not support this assertion; rather, if history repeats itself, the denial of benefits on the basis of nicotine addiction could have more detrimental than beneficial effects, in terms of the rates of treatment, homelessness, drug usage, and drug-related crime that would result from the loss of benefits.¹¹⁵ Several studies of persons whose benefits were terminated by the 1996 amendments support this outcome.¹¹⁶

In 2002, Dru Stevenson, a public benefits advocate and researcher with Greater Hartford Legal Aid, wrote an article collecting and analyzing the empirical data produced by studies of persons whose benefits were terminated by the 1996 amendments creating the DA&A analysis.¹¹⁷ These studies showed that “reform measures [e.g., the 1996 amendments] did not foster incentives for addicts to rehabilitate themselves at greater rates than when they received benefits,”¹¹⁸ and that the “receipt of public benefits did not

113. Meisburg, *supra* note 6, at 40.

114. *Id.*

115. *See infra* notes 116-127 and accompanying text.

116. *See infra* notes 116-127 and accompanying text.

117. Stevenson, *supra* note 11 at 36.

118. *Id.* at 200 (noting that a Chicago-area study on the impact of the 1996 amendments on treatment participation found that patients were three times as likely to drop out of their treatment after termination of benefits and that the average length of treatment decreased 55% after the 1996 amendments were implemented). *See also id.* at 196-98 (discussing the study conducted by the Lewin

encourage increased drug use, but lowered it.”¹¹⁹ Addicts whose benefits were terminated were less likely to seek and stay in treatment, and more likely to become homeless, resort to crime rather than returning to the work force, and commit suicide.¹²⁰

These studies suggest, and Stevenson concludes, that while withholding benefits could deter individuals from becoming addicts in the first place, receipt of benefits by current addicts is unlikely to increase consumption of the addictive substance, or “encourage or increase drug or alcohol dependency.”¹²¹ Rather, “[p]ublic assistance [such as SSI and SSD benefits] provides a stabilizing influence” in the life of the addict, allowing the addict to retain housing and seek professional treatment of the problem, two steps essential toward recovery from addiction.¹²²

Stevenson’s conclusions were supported by the findings of the “SSI Study,” the results of which were published in 2003 in *Contemporary Drug Problems*.¹²³ The SSI Study surveyed a group of former SSI recipients who lost their benefits due to the 1996

Group on behalf of the Social Security Administration in 1997 and 1998, which “found ‘virtual unanimity’ that former beneficiary participation in treatment programs ‘dropped dramatically’” due to the loss of benefits, and the study presented by the Association of Health Services Research, which found that one year following the termination of benefits for addicts, participation in outpatient treatment programs steadily declined, whereas those persons in treatment programs whose benefits continued had higher levels of participation one year after the 1996 amendments).

119. Stevenson, *supra* note 11, at 201; *see also id.* at 196-201 (discussing the particular studies used to come to this conclusion).

120. *Id.* at 196-201; *see also* Dean Spade, *Undeserving Addicts: SSI/SSD and the Penalties of Poverty*, HOW. SCROLL SOC. JUST. L. REV. 89, 100 (discussing studies tracking the effects of the 1996 amendments which found that persons who lost benefits were more likely to be homeless, to engage in illegal activities, and had an increased rate of substance abuse).

121. Stevenson, *supra* note 11, at 216, 219; *see also* Spade, *supra* note 119, at 101 (noting that studies have concluded that “disqualifying drug users from public income supports may well increase drug use among [injection drug users]”).

122. Stevenson, *supra* note 11, at 223.

123. 30 CONTEMP. DRUG PROBS. 1, 1-537 (2003) (this journal devoted its 2003 Spring and Summer editions to the results of the SSI Study, published as 16 related papers).

amendments over the two years following loss of benefits.¹²⁴ This study found that persons who lost SSI benefits only returned to the work force in a relative minority of cases,¹²⁵ were more likely to experience homelessness and hunger than persons who retained SSI benefits,¹²⁶ and were not any more likely to stop using drugs or alcohol than persons who retained benefits, a finding which was used to support the conclusion that “cash assistance programs [do not] promote continued substance abuse.”¹²⁷ The SSI Study also found that persons who lost SSI benefits were less likely to participate in treatment programs and more likely to commit drug-related crimes.¹²⁸

As demonstrated by these studies, a flat denial of benefits under the DA&A analysis seems to have several negative consequences for the claimant, and therefore, the public at large: claimants are less likely to seek treatment that could enable them to return to the work force and more likely to encounter the social pitfalls of homelessness,

124. See James Swartz et al., *The Methodology of the Multi-Site Study of the Termination of Supplemental Security Income Benefits for Drug Addicts and Alcoholics*, 30 CONTEMP. DRUG PROBS. 77 (2003) (discussing the quantitative and qualitative methodologies used in the SSI Study).

125. See Kevin Campbell et al., *The Bottom Line: Employment and Barriers to Work Among Former SSI DA&A Beneficiaries*, 30 CONTEMP. DRUG PROBS. 195, 195 (2003) (finding that of the former beneficiaries surveyed, only 25% earned \$500 or more per month, and only 12% earned that much throughout the two-year period of the study, and concluding that many former beneficiaries would remain indigent).

126. See Jean Norris et al., *Homelessness, Hunger and Material Hardship Among Those Who Lost SSI*, 30 CONTEMP. DRUG PROBS. 241, 256-58 (2003).

127. See Richard Speigman et al., *SSI Receipt and Alcohol and Other Drug Use Among Former SSI DA&A Beneficiaries*, 30 CONTEMP. DRUG PROBS. 291, 325 (2003).

128. See James A. Swartz et al., *Drug Treatment Participation and Retention Rates Among Former Recipients of Supplemental Security Income for Drug Addiction and Alcoholism*, 30 CONTEMP. DRUG PROBS. 335 (2003). See also Deborah Podus et al., *Medical and Mental Health Services Utilization Among Requalified and Former Drug Addiction and Alcoholism Recipients of SSI*, 30 CONTEMP. DRUG PROBS. 365, 383 (2003) (finding that persons who lost SSI benefits were significantly less likely to receive medical care, mental health care, or both, than persons who re-qualified for benefits, and concluding that “[t]his disparity confirms the frequent finding of lower access to care for uninsured groups and, for this population, appears to be an adverse impact associated with the policy change [of implementation of the 1996 amendments]”).

increased illegal activity, and increased drug use.¹²⁹ Rather than having a “public policy salutary effect,”¹³⁰ this program appears to be capable of doing more harm than good.

The argument could be made that the denial of benefits based on nicotine abuse is unlikely to have the same or similar results demonstrated by studies focusing on intravenous or illegal drug abuse, or alcohol, since nicotine is not only less expensive than intravenous or illegal drugs, but also legal for adults to purchase. However, alcohol is also less expensive than intravenous drugs and legal for adults to purchase, yet it is included in the DA&A analysis and denial of benefits on this basis has resulted in the negative public policy effects discussed above.¹³¹ As noted during the discussion of the duty to follow prescribed treatment, several courts have already recognized the similarities between addiction to nicotine and alcoholism.¹³² If it is assumed, for the purposes of argument, that nicotine addiction falls under the DA&A analysis, it seems only fair to also assume that denial of benefits based on nicotine addiction will have similar effects on disability claimants as seen with the denial of benefits based on alcoholism. As discussed in this section, these effects would likely have a greater negative impact than a “salutary effect”¹³³ in terms of public policy.

V. CONCLUSION

As mentioned above, Judge Meisburg’s most recent treatment of the issue of nicotine abuse and disability concludes that “disability benefits can and should be denied” to smokers.¹³⁴ While the law with respect to the duty to follow prescribed medical treatment and the DA&A analysis makes it *possible* for the finder of fact in a disability determination to deny benefits on the grounds of continued tobacco abuse, the issue of whether the finder of fact *should* do so is not so clear. The law of the circuit courts has created as many

129. See *supra* notes 116-27 and accompanying text.

130. Meisburg, *supra* note 6, at 40.

131. See *supra* notes 116-27 and accompanying text.

132. See *supra* notes 70-71 and accompanying text.

133. Meisburg, *supra* note 6, at 40.

134. *Id.*

questions as answers in the “prescribed treatment” determination, making it clear that a blanket prohibition simply will not do.¹³⁵ Additionally, the law related to whether the DA&A analysis will even apply to nicotine addiction is unsettled and perhaps not as clear-cut, even in theory, as Judge Meisburg would have it be.¹³⁶

Overall, it appears that a hard and fast rule denying benefits to smokers based either upon the failure to follow prescribed treatment or the DA&A analysis is not warranted by the current state of the law, and, as a matter of public policy, is perhaps not the best course of action. While it is undeniable that tobacco abuse is a highly relevant issue with respect to Social Security law and the general health of the nation, the harsh treatment of Social Security claimants suggested by Judge Meisburg is not the only, or perhaps even the wisest, course of action. Under the current law, it seems that a case-by-case determination of the level of impact tobacco abuse will have on the disability determination is warranted, with special attention given to the concerns articulated by the courts in the four-factor “prescribed treatment” analysis and any future decisions that may decide whether the DA&A analysis should in fact be applied to nicotine addicts, so that disability claimants who are also smokers can receive a fair and equitable determination of their claims, and the public in general can derive the most benefit possible from the laws that Congress and the Social Security Administration have seen fit to enact.

135. *Supra* notes 45-81 and accompanying text.

136. *Supra* notes 99-111 and accompanying text.